Patient Safety
April, 2003

1: AAOHN J 2003 Mar;51(3):126-34
Preventing nursing back injuries: redesigning patient handling tasks.
Nelson A, Lloyd JD, Menzel N, Gross C.
Veterans Health Administration, Patient Safety Center of Inquiry, Tampa, FL, USA.
The researchers identified nine patient handling tasks that place nursing staff at high risk for musculoskeletal injuries. An expert panel redesigned these tasks using new patient handling technologies and work practice controls. The key objective was to evaluate the biomechanical benefit of the redesigned tasks. Back and shoulder muscle activity, forces on the lumbar spine, shoulder joint moments, and perceived comfort were evaluated in a laboratory setting. Using objective and subjective data, 63 participants who performed the redesigned tasks were compared with 71 participants who used standard procedures. Objective data revealed significant improvement in five of the redesigned tasks, while staff subjectively rated four of the redesigned tasks as significantly improved. Nursing tasks can be redesigned to improve caregiver and patient safety using new patient handling technologies and work practice controls. Further study is needed to redesign other high risk tasks to promote safer work environments.
PMID: 12670100 [PubMed - in process]

2: Acad Emerg Med 2003 Apr;10(4):364-7
Profiles in patient safety: emergency care transitions.
Beach C, Croskerry P, Shapiro M.
Department of Emergency Medicine, University of Florida HSC/Jacksonville, FL.
A 59-year-old man presented to the emergency department (ED) with the chief complaint of "panic attacks." In total, he was evaluated by 14 faculty physicians, 2 fellows, and 16 residents from emergency medicine, cardiology, neurology, psychiatry, and internal medicine. These multiple transitions were responsible, in part, for the perpetuation of a failure to accurately diagnose the patient's underlying medical illness. The case illustrates the discontinuity of care that occurs at transitions, which may threaten the safety and quality of patient care. Considerable effort must be directed at making transitions effective and safe. Recommendations to improve transitions include a heightened awareness of cognitive biases operating at these vulnerable times, improving team situational awareness and communication, and exploring systems to facilitate effective transfer of relevant data.
PMID: 12670851 [PubMed - in process]

3: Am J Respir Crit Care Med 2003 Mar 15;167(6):809-10

Comment on:
Am J Respir Crit Care Med. 2003 Mar 15;167(6):824-7.
Rifampin and pyrazinamide for treatment of latent tuberculosis infection: is it safe?
Jasmer RM, Daley CL.
PMID: 12623855 [PubMed - indexed for MEDLINE]

4: Am J Respir Crit Care Med 2003 Mar 1;167(5):676-7
Comment on:
Am J Respir Crit Care Med. 2003 Mar 1;167(5):723-5.
Sputum induction: simpler, cheaper, and safer--but is it better?
Menzies D.
PMID: 12598210 [PubMed - indexed for MEDLINE]

5: Anaesthesia 2003 Mar;58(3):233-42
Anaesthetists' attitudes to teamwork and safety.
Flin R, Fletcher G, McGeorge P, Sutherland A, Patey R.
Department of Psychology, University of Aberdeen, King's College, Aberdeen, AB24 2UB, UK.
A questionnaire survey was conducted with 222 anaesthetists from 11 Scottish hospitals to measure their attitudes towards human and organisational factors that can have an impact on effective team performance and consequently on patient safety. A customised version of the Operating Room Management Attitude Questionnaire (ORMAQ) was used. This measures attitudes to leadership, communication, teamwork, stress and fatigue, work values, human error and organisational climate. The respondents generally demonstrated positive attitudes towards the interpersonal aspects of their work, such as team behaviours and they recognised the importance of communication skills, such as assertiveness. However, the results suggest that some anaesthetists do not fully appreciate the debilitating effects of stress and fatigue on performance. Their responses were comparable with (and slightly more favourable than) those reported in previous ORMAQ surveys of anaesthetists and surgeons in other countries.
PMID: 12603453 [PubMed - indexed for MEDLINE]

6: Ann Intern Med 2003 Mar 18;138(6):I56
Original report in:
Ann Intern Med. 2003 Mar 18;138(6):468-71.
Summaries for patients. Ephedra is associated with more adverse effects than other herbs.
Publication Types:
Patient Education Handout
PMID: 12639104 [PubMed - indexed for MEDLINE]

7: Ann Intern Med 2003 Mar 18;138(6):468-71
Summary for patients in:
Ann Intern Med. 2003 Mar 18;138(6):I56.
The relative safety of ephedra compared with other herbal products.
Bent S, Tiedt TN, Odden MC, Shlipak MG.
Osher Center for Integrative Medicine at the University of California, San Francisco, and San Francisco Veterans Affairs Medical Center, San Francisco, 111-A1, 4150 Clement Street, San Francisco, California 94121, USA. bent@itsa.ucsf.edu
BACKGROUND: Ephedra is widely used in dietary supplements that are marketed to promote weight loss or increase energy; however, the safety of this product has

been questioned because of numerous case reports of adverse events. OBJECTIVE: To compare the risk for adverse events attributable to ephedra and other herbal products. DESIGN: Comparative case series. SETTING: American Association of Poison Control Centers Toxic Event Surveillance System Database Annual Report, 2001. MEASUREMENTS: The relative risk and 95% confidence interval for experiencing an adverse reaction after ephedra use compared with other herbs. This risk was defined as the ratio of adverse reactions to ephedra versus other products, divided by the ratio of their relative use in the United States. RESULTS: Products containing ephedra accounted for 64% of all adverse reactions to herbs in the United States, yet these products represented only 0.82% of herbal product sales. The relative risks for an adverse reaction in persons using ephedra compared with other herbs were extremely high, ranging from 100 (95% CI, 83 to 140) for kava to 720 (CI, 520 to 1100) for Ginkgo biloba. CONCLUSIONS: Ephedra use is associated with a greatly increased risk for adverse reactions compared with other herbs, and its use should be restricted.
PMID: 12639079 [PubMed - indexed for MEDLINE]

8: Biomed Instrum Technol 2003 Mar-Apr;37(2):96-102
How to make the most of failure mode and effect analysis.
Stalhandske E, DeRosier J, Patail B, Gosbee J.
Department of Veterans Affairs National Center for Patient Safety, 24 Frank Lloyd Wright Drive, Lobby M, PO Box 486, Ann Arbor, MI 48106, USA. Erik.Stalhandske@MED.VA.GOV
Current accreditation standards issued by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) require hospitals to carry out a proactive risk assessment on at least 1 high-risk activity each year for each accredited program. Because hospital risk managers and patient safety managers generally do not have the knowledge or level of comfort for conducting a proactive risk assessment, they will appreciate the expertise offered by biomedical equipment technicians (BMETs), occupational safety and health professionals, and others. The skills that have been developed by BMETs and others while conducting job safety analyses or failure mode effect analysis can now be applied to a health care proactive analysis. This article touches on the Health Care Failure Mode and Effect Analysis (HFMEA) model that the Department of Veterans Affairs (VA) National Center for Patient Safety developed for proactive risk assessment within the health care community. The goal of this article is to enlighten BMETs and others on the growth of proactive risk assessment within health care and also on the support documents and materials produced by the VA. For additional information on HFMEA, visit the VA website at www.patientsafety.gov/HFMEA.html.
PMID: 12677747 [PubMed - in process]

9: Biomed Instrum Technol 2003 Mar-Apr;37(2):128-30
Not by technology alone .... Project seeks to assess and aid patient safety in rural areas.
Cook AF, Hoas H, Guttmannova K.
Department of Psychology, University of Montana, Missoula, MT 59812, USA. anncook@selway.umt.edu
PMID: 12677753 [PubMed - in process]

10: Can J Anaesth 2003 Apr;50(4):319-22
Patient safety in anesthesia - continuing challenges and opportunities/La securite du patient en anesthesie - possibilites et defis permanents.
Wade JG.
Department of Anesthesia, University of Manitoba, Winnipeg, Manitoba, Canada.

PMID: 12670805 [PubMed - in process]

11: Circulation 2003 Mar 31; [epub ahead of print]
Quantitative Ischemia Detection During Cardiac Magnetic Resonance Stress Testing by Use of FastHARP.
Kraitchman DL, Sampath S, Castillo E, Derbyshire JA, Boston RC, Bluemke DA, Gerber BL, Prince JL, Osman NF.
Johns Hopkins University, School of Medicine, Departments of Radiology and Medicine, Division of Cardiology, and Department of Electrical Engineering, Baltimore, Md; National Institutes of Health, National Heart, Lung, and Blood Institute, Bethesda, Md; and University of Pennsylvania, School of Veterinary Medicine, Kennett Square, Pa.
BACKGROUND: Because ECG alterations caused by ischemia cannot be reliably detected in the high-field MRI environment, detection of wall motion abnormalities is often used to ensure patient safety during stress testing. However, an experienced observer is needed to detect these abnormalities. In this study, we investigate the use of fast harmonic phase (FastHARP) MRI for the quantitative, operator-independent detection of the onset of ischemia during acute coronary occlusion. METHODS AND RESULTS: Eight mongrel dogs underwent an
acute 2-minute closed-chest coronary artery occlusion while continuous FastHARP images were acquired. Full regional wall strain was determined every other heartbeat in a single short-axis imaging slice. After 5 minutes of reperfusion, a second 2-minute ischemic episode was induced during the acquisition of conventional cine wall-motion images. The time at which ECG alterations were observed during the first ischemic period was recorded. The time from occlusion to the detection of ischemia, based on a consensus of 2 blinded observers, was determined for MRI. No significant ischemia was present in 2 animals. In the remaining animals, the onset of ischemia was detected significantly earlier by FastHARP than by cine MRI (9.5+/-5 versus 33+/-14 seconds, $P<0.01$). HARP ischemia detection preceded ECG changes, on average, by 54 seconds.
CONCLUSIONS:
The rapid acquisition and detection of induced ischemia with FastHARP MRI shows promise as a nonsubjective method to diagnose significant coronary lesions during MR stress testing.
PMID: 12668517 [PubMed - as supplied by publisher]

12: Clin Lab Sci 2003 Winter;16(1):4-5
Patient safety concerns grow in Congress.
Hansen K, Lavanty D.
ASCLS Government Affairs Committee, Bethesda, MD 20814, USA.
PMID: 12587651 [PubMed - indexed for MEDLINE]

13: Crit Care Med 2003 Apr;31(4):S305-11
Improving clinical trial design in acute lung injury.
Wood KA, Huang D, Angus DC.
If future trials of acute lung injury/acute respiratory distress syndrome are to be rigorous, informative, and successful, a number of key design issues need to be considered. First, appropriate sample size and entry criteria must be selected. The present definitions of acute lung injury/acute respiratory distress syndrome are arbitrary and select a broad, heterogeneous patient population in which treatment effects may often be small, requiring much larger sample sizes than those of previous trials. The alternative approach, selecting a subset of patients in whom a larger benefit is anticipated, is potentially hazardous because the subset selection criteria are unproven. Second, it must be

ensured that the therapy is tested against current best methods of care. To ensure that a study is considered current at completion, investigators should anticipate that recent evidence at study commencement will be considered standard at study completion. Up-to-date evidence-based medicine should therefore be encouraged for all enrolled patients and, probably, protocolized in unblinded studies. Multiple novel therapies can also be tested, but care must be paid to the particular study design choice. Third, appropriate outcomes must be chosen. The traditional end point of 28-day mortality is too short and too crude to capture all relevant patient and societal outcomes. Thus, consideration of survival over a longer duration, coupled with assessment of quality of life, functional status, and morbidity, is essential. Fourth, the study must comply with new standards for the protection of human subjects. Protecting human subjects' rights and ensuring patient safety in subjects who are critically ill and who are rarely able to provide fully informed consent is a significant challenge. However, it is essential that new studies comply with required standards without becoming so burdensome that they cannot reasonably be completed.
PMID: 12682457 [PubMed - in process]

14: Crit Care Med 2003 Mar;31(3):823-9
Long-term mechanical ventilation with hygroscopic heat and moisture exchangers used for 48 hours: a prospective clinical, hygrometric, and bacteriologic study.
Boyer A, Thiery G, Lasry S, Pigne E, Salah A, de Lassence A, Dreyfuss D, Ricard JD.
Services de Reanimation Medicale, Hopital Louis Mourier (Assistance Publique-Hopitaux de Paris), Colombes, France.
OBJECTIVE: To determine whether use of a hygroscopic heat and moisture exchanger
(HME) for 48 hrs without change affects its efficiency and the level of bacterial colonization in long-term mechanically ventilated medical intensive care unit patients. DESIGN: Prospective, randomized clinical study evaluating two hygroscopic HMEs. SETTING: Medical intensive care unit at a university teaching hospital. PATIENTS: Long-term mechanically ventilated medical intensive care unit patients, including chronic obstructive pulmonary disease patients. INTERVENTIONS: Patients were randomly allocated to one of the two HMEs studied (Hygrolife and EdithFlex) and changed every 48 hrs. Devices in both groups could be changed if hygrometric measurements indicated insufficient humidity delivery. MEASUREMENTS AND MAIN RESULTS: Daily measurements of inspired gas temperature
and relative and absolute humidity. In addition, cultures of tracheal aspirations and both patient and ventilator sides of the device were performed after 48 hrs of use. Ventilatory variables and clinical indicators of efficient humidification were also recorded. Prolonged use of both HMEs was safe and efficient (no tracheal tube occlusion occurred). Mean duration of mechanical ventilation was 20 days. Both clinical indicators and hygrometric measurements showed that both devices performed well during 48 hrs. Absolute humidity with EdithFlex was significantly higher on day 0 and day 1 than with Hygrolife. Absolute humidity measured in chronic obstructive pulmonary disease patients was identical to that measured in the rest of the study population. Tracheal colonization and HME colonization were similar with both HMEs. Bacterial contamination of the ventilator side of both devices was markedly low. CONCLUSIONS: These two purely hygroscopic HMEs provided safe and efficient humidification during a 48-hr period of use in long-term mechanically ventilated medical intensive care unit patients, including chronic obstructive pulmonary disease patients. In addition, they maintained ventilatory circuits clean,

despite the absence of filtering media. The cost of mechanical ventilation is consequently reduced.
PMID: 12626991 [PubMed - indexed for MEDLINE]

15: Crit Care Med 2003 Mar;31(3):711-7
Safety of sedation with ketamine in severe head injury patients: comparison with sufentanil.
Bourgoin A, Albanese J, Wereszczynski N, Charbit M, Vialet R, Martin C.
Department of Anesthesiology, Marseille University Hospital System, France.
OBJECTIVE: The aim of the study was to compare the safety concerning cerebral hemodynamics of ketamine and sufentanil used for sedation of severe head injury patients, both drugs being used in combination with midazolam. DESIGN: Prospective, randomized, double-blind study. SETTING: Intensive care unit in a trauma center. PATIENTS: Twenty-five patients with severe head injury. INTERVENTIONS: Twelve patients received sedation with a continuous infusion of ketamine-midazolam and 13 with a continuous infusion of sufentanil-midazolam. All patients were mechanically ventilated with moderate hyperventilation. MEASUREMENTS AND MAIN RESULTS: Prognostic indicators (age, Glasgow Coma Scale
scores, computed tomography diagnosis, and Injury Severity Scale score) were similar in the two groups at study entry. Measurements were carried out during the first 4 days of sedation. The average infusion rates during this time were 82 +/- 25 micro x kg x min ketamine and 1.64 +/- 0.5 microg x kg x min midazolam in the ketamine group and 0.008 +/- 0.002 microg x kg x min sufentanil and 1.63 +/- 0.37 microg x kg x min midazolam in the sufentanil group. No significant differences were observed between the two groups in the mean daily values of intracranial pressure and cerebral perfusion pressure. The numbers of intracranial pressure elevations were similar in both groups. The requirements of neuromuscular blocking agents, propofol, and thiopental were similar. Heart rate values were significantly higher in the ketamine group on therapy days 3 and 4 (<.05). With regard to arterial pressure control, more fluids were given on the first therapy day and there was a trend toward greater use of vasopressors in the sufentanil group. Sedative costs were similar in the two groups. CONCLUSION: The results of this study suggest that ketamine in combination with midazolam is comparable with a combination of midazolam-sufentanil
in maintaining intracranial pressure and cerebral perfusion pressure of severe head injury
patients placed under controlled mechanical ventilation.
PMID: 12626974 [PubMed - indexed for MEDLINE]

16: Gastroenterology 2003 Mar;124(3):642-50
Interferon-alpha 2b plus ribavirin in patients with chronic hepatitis C after liver transplantation: a randomized study.
Samuel D, Bizollon T, Feray C, Roche B, Ahmed SN, Lemonnier C, Cohard M, Reynes M, Chevallier M, Ducerf C, Baulieux J, Geffner M, Albrecht JK, Bismuth H, Trepo C.
Centre HepatoBiliaire, Hopital Paul Brousse Assistance Publique-Hopitaux de Paris, Faculte de Medecine Paris Sud, EA 3541, EPI 99-41 et Association Claude Bernard, Villejuif, France. didier.samuel@pbr.ap-hop-paris.fr
BACKGROUND AND AIMS: Hepatitis C virus (HCV) reinfection after liver transplantation is frequent and leads to chronic hepatitis and cirrhosis. The use of antiviral therapy in this situation remains controversial. This study aimed to assess the safety and efficacy of interferon alfa-2b plus ribavirin for recurrent hepatitis C following liver transplantation. METHODS: Transplant

recipients with recurrent chronic hepatitis C were randomized to receive either no treatment or therapy with interferon alfa-2b (3 MU 3 times a week) plus 1000-1200 mg/day ribavirin for 1 year. Patients were followed up for 6 months after the end of treatment. The primary end point was loss of HCV RNA 6 months after the end of treatment. RESULTS: Fifty-two patients were randomized (treatment, 28; placebo, 24). Sixteen patients were withdrawn from the study; 12 (43%) were from the treated group (mainly for anemia [7 patients]) and 4 (17%) from the control group. In the treated group, serum HCV RNA was undetectable in 9 patients (32%) at the end of treatment and 6 (21.4%) at the end of the follow-up period, whereas no patient in the control group lost HCV RNA at any point (P = 0.036 at the end of follow-up). However, there was no significant histologic improvement. CONCLUSIONS: The combination of interferon alfa-2b plus ribavirin induced a sustained virologic response in 21% of transplant recipients with recurrent hepatitis C. However, 43% discontinued therapy due to adverse events (primarily severe anemia). Strategies to enable treatment with lower doses of ribavirin need to be explored.
PMID: 12612903 [PubMed - indexed for MEDLINE]

17: GHA Today 2003 Jan;47(1):1, 4-6
Health policy expert discusses PHA, national patient safety efforts.
Thorpe K.
PMID: 12658956 [PubMed - in process]

18: Health Aff (Millwood) 2003 Mar-Apr;22(2):73-83
Hospital disclosure practices: results of a national survey.
Lamb RM, Studdert DM, Bohmer RM, Berwick DM, Brennan TA.
Radio New Zealand in Wellington.
New patient safety standards from JCAHO that require hospitals to disclose to patients all unexpected outcomes of care took effect 1 July 2001. In an early 2002 survey of risk managers at a nationally representative sample of hospitals, the vast majority reported that their hospital's practice was to disclose harm at least some of the time, although only one-third of hospitals actually had board-approved policies in place. More than half of respondents reported that they would always disclose a death or serious injury, but when presented with actual clinical scenarios, respondents were much less likely to disclose preventable harms than to disclose nonpreventable harms of comparable severity. Reluctance to disclose preventable harms was twice as likely to occur at hospitals having major concerns about the malpractice implications of disclosure.
PMID: 12674409 [PubMed - in process]

19: Health Aff (Millwood) 2003 Mar-Apr;22(2):113-5
A call to excellence.
Clancy CM, Scully T.
Agency for Healthcare Research and Quality in Rockville, Maryland, USA.
Health care improvement affects us all and is not optional. For change to occur, consumers must demand excellence from their providers and clinicians. Patient safety is part of a broader set of health care quality issues. Championing this view will not be easy, for it means fundamental change to the myriad interrelated systems that make up U.S. health care. HHS is taking the lead on patient safety through a number of initiatives and activities.
PMID: 12674413 [PubMed - in process]

20: Health Aff (Millwood) 2003 Mar-Apr;22(2):116-8

Provider responsibility and system redesign: two sides of the same coin.
Richardson WC, Corrigan JM.
W K Kellogg Foundation in Battle Creek, Michigan, USA.
Patient safety is a serious problem that health care professionals and hospitals must confront. The health care delivery system must be redesigned. Health care professionals have a moral and ethical responsibility to actively participate in the development and operation of well-designed care processes. Efforts to redesign the delivery system will be most effective if accompanied by changes in the environment that shapes care delivery. Health care leadership must also focus attention on identifying the types of environmental changes needed at different levels, and on the part of specific stakeholders, to allow model twenty-first-century community health systems to develop.
PMID: 12674414 [PubMed - in process]

21: Health Aff (Millwood) 2003 Mar-Apr;22(2):46-59
The leapfrog standards: ready to jump from marketplace to courtroom?
Mello MM, Studdert DM, Brennan TA.
Harvard School of Public Health, USA.
The Leapfrog Group, a consortium of large employers, aims to use its collective purchasing power to motivate hospitals to implement particular measures designed to improve patient safety and the quality of care. While these criteria are meant to be purely aspirational, and while Leapfrog's effort is praiseworthy, we caution that the articulation of these standards of care may have unintended legal consequences. Efforts by aggressive medical malpractice attorneys could rapidly transform Leapfrog's standards from marketplace advantages for compliant hospitals to performance expectations required by law. This undesirable potential outcome compounds the importance of selecting these standards with the utmost care.
PMID: 12674407 [PubMed - in process]

22: Health Aff (Millwood) 2003 Mar-Apr;22(2):154-66
A national profile of patient safety in U.S. hospitals.
Romano PS, Geppert JJ, Davies S, Miller MR, Elixhauser A, McDonald KM.
Division of General Medicine, University of California, Davis, USA.
Measures based on routinely collected data would be useful to examine the epidemiology of patient safety. Extending previous work, we established the face and consensual validity of twenty Patient Safety Indicators (PSIs). We generated a national profile of patient safety by applying these PSIs to the HCUP Nationwide Inpatient Sample. The incidence of most nonobstetric PSIs increased with age and was higher among African Americans than among whites. The adjusted incidence of most PSIs was highest at urban teaching hospitals. The PSIs may be used in AHRQ's National Quality Report, while providers may use them to screen for preventable complications, target opportunities for improvement, and benchmark performance.
PMID: 12674418 [PubMed - in process]

23: Hosp Peer Rev 2003 Apr;28(4):suppl 3-4
Patient Safety Alert. Pfizer to bar code drugs to reduce dispensing errors.
PMID: 12683098 [PubMed - in process]

24: Hosp Peer Rev 2003 Apr;28(4):suppl 1-3
Patient Safety Alert. Retained instruments: rare error or safety concern?
PMID: 12683097 [PubMed - in process]

25: J Am Med Inform Assoc 2003 Mar-Apr;10(2):226-8

Comment on:
J Am Med Inform Assoc. 2003 Mar-Apr;10(2):115-28.
Policy and the future of adverse event detection using information technology.
Bates DW, Evans RS, Murff H, Stetson PD, Pizziferri L, Hripcsak G.
Division of General Medicine, Department of Medicine, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115, USA. dbates@partners.org
PMID: 12595412 [PubMed - indexed for MEDLINE]

26: J Fam Pract 2003 Mar;52(3):227-8
Patient safety after hours: time for action.
Hickner J.
Department of Family Practice, Michigan State University, East Lansing 44824-1315, USA. john.hickner@ht.msu.edu
PMID: 12620178 [PubMed - indexed for MEDLINE]

27: J Fam Pract 2003 Mar;52(3):222-7
After-hours telephone triage affects patient safety.
Hildebrandt DE, Westfall JM, Smith PC.
Rose Family Medicine Residency, Denver, CO 80222, USA. hildebrd@rfmr.com
OBJECTIVE: To describe the management of after-hours calls to primary care physicians and identify potential errors that might delay evaluation and treatment. STUDY DESIGN: Survey of primary care practices and audit of after-hours phone calls. Ninety-one primary care offices (family medicine, internal medicine, obstetrics, and pediatrics) were surveyed in October and November 2001. Data collected included number of persons answering the calls, information requested, instructions to patients, who decided whether to contact the on-call physician, and subsequent handling of all calls. We evaluated all after-hours calls to an index office that were not forwarded to the on-call physician. Four family physicians independently reviewed the calls while unaware that these calls had not been forwarded to the physician on call to determine the appropriate triage. POPULATION: Primary care physicians and their telephone answering services. OUTCOME MEASURES (1) Who decided to initiate immediate contact with the physician? (2) Percentage of calls identified as emergent or nonemergent by patients. (3) Independent physician ratings of nonemergent calls. RESULTS: More than two thirds of the offices used answering services to take their calls. Ninety-three percent of the practices required the patient to decide whether the problem was emergent enough to require immediate notification of the on-call physician. Physician reviewers reported that 50% (range, 22%-77%) of the calls not forwarded to the on-call physician represented an emergency needing immediate contact with the physician. CONCLUSIONS: After-hours call systems in most primary care offices impose barriers that may delay care. All clinical patient calls should be sent to appropriately trained medical personnel for triage decisions. We urge all clinicians that use an answering service to examine their policies and procedures for possible sources of medical error.
PMID: 12620177 [PubMed - indexed for MEDLINE]

28: J Healthc Qual 2003 Mar-Apr;25(2):26-7, 37
Beth Lanham on Six Sigma in healthcare, Interview by Luc R. Pelletier.
Lamham B.
Beth Lanham, BSN RN, is a Six Sigma Coordinator in the department of quality management, staff development and safety, at Froedtert Hospital in Milwaukee, WI. Ms. Lanham received her bachelor's degree from Otterbein College in Westerville, OH and has an extensive clinical and management background in critical care nursing. In April 2000, Ms. Lanham completed the Six Sigma Black Belt training program through the American Society for Quality. She is currently

working as a Six Sigma Black Belt and is actively involved with numerous committees and projects aimed at reducing medical errors and enhancing patient safety. Ms. Lanham has presented Six Sigma initiatives at the International Quality Congress sponsored by the American Society for Quality, the University Healthcare Consortium National Conference, the International Quality and Productivity Center National Conference on Six Sigma for Healthcare Providers, and the American Hospital Association Patient Safety Leadership Fellowship Retreat. Six Sigma projects at Froedtert Hospital are aimed at reducing errors associated with patient controlled analgesia pumps, continuous intravenous infusions, narcotic sedation in postoperative patients, insulin therapy, and handling of laboratory specimens. Six Sigma has also been applied toward reducing falls on a rehabilitation unit.
PMID: 12659077 [PubMed - in process]

29: J Healthc Qual 2003 Mar-Apr;25(2):47-8
Patient safety initiatives explored at third annual medical errors and patient safety conference.
Seisser MA.
CNA HealthPro, Chicago, IL, USA.
PMID: 12659080 [PubMed - in process]

29: J Leg Med 2003 Mar;24(1):1-6
Changing the culture of patient safety and medical errors.
Basanta WE.
Interim Dean and Professor, School of Law and Professor, School of Medicine, Department of Medical Humanities, Southern Illinois University.
PMID: 12623692 [PubMed - in process]

30: Jt Comm J Qual Saf 2003 Mar;29(3):152-5
Video-storytelling: a step-by-step guide.
Maund T, Espinosa JA, Kosnik LK, Scharf J.
Atlantic Health System/Overlook Hospital, Summit, New Jersey, USA.
PMID: 12635431 [PubMed - indexed for MEDLINE]

31: Jt Comm J Qual Saf 2003 Mar;29(3):146-51
Using a market model to track advances in patient safety.
Shulkin D.
Department of Medicine, Drexel University School of Medicine, Philadelphia, USA. David.Shulkin@tenethealth.com
The author proposes a four-stage model that may help hospitals and other health care providers recognize and anticipate market drivers of patient safety.
PMID: 12635430 [PubMed - indexed for MEDLINE]

32: Jt Comm J Qual Saf 2003 Mar;29(3):124-33
A multihospital safety improvement effort and the dissemination of new knowledge.
Mills PD, Weeks WB, Surott-Kimberly BC.
Veterans Affairs National Center for Patient Safety, White River Junction, Vermont, USA. peter.mills@med.va.gov
BACKGROUND: Research on the transfer of medical technology and guidelines suggests that this transfer is driven more by interpersonal relationships than by new research or available information and that it is inconsistent, largely unsuccessful, and strongly influenced by local factors. Yet studies of collaborative, multiple-hospital improvement efforts have shown these transfers to be effective for the specific microsystems participating in the project. The

diffusion of medical innovations beyond the participating teams was studied during a 2000-2001 national collaborative safety improvement effort. METHODS: Twenty-two teams from Department of Veterans Affairs (VA) hospitals participated in a 9-month quality improvement project designed to improve safety in high-hazard areas. Participating hospitals and other regional hospitals were contacted to determine the level of dissemination of information generated during and after the project. RESULTS: While the participating hospitals benefited from the quality improvement effort, changes were implemented only 9% of the time on other units within the hospitals and only 2% of the time in other regional hospitals. After 12 months, there was no implementation within participating hospitals, and other regional hospitals were implementing changes 10% of the time. DISCUSSION: Personal commitment from senior leadership, dissemination strategies that push information to clinicians, and monitoring of progress at the regional level are all needed for dissemination of complex medical information to occur.
PMID: 12635428 [PubMed - indexed for MEDLINE

33: N Engl J Med 2003 Apr 3;348(14):1393-401
Comment in:
N Engl J Med. 2003 Apr 3;348(14):1377-80.
How best to ventilate? Trial design and patient safety in studies of the acute respiratory distress syndrome.
Steinbrook R.
PMID: 12672870 [PubMed - indexed for MEDLINE]

34: N Engl J Med 2003 Mar 13;348(11):1051-6
Understanding and responding to adverse events.
Vincent C.
Department of Surgical Oncology and Technology, Imperial College School of Science, Technology, and Medicine, St. Mary's Hospital, London.
PMID: 12637617 [PubMed - indexed for MEDLINE]

35: Nurs Manage 2003 Apr;34(4):48-51
Patient safety: Take the informatics challenge.
Abrahamsen C.
To provide safe, efficient patient care, keep pace with the ever-evolving world of nursing informatics.
PMID: 12671410 [PubMed - in process]

36: Qual Manag Health Care 2003 Jan-Mar;12(1):46-52
St. John Health System and patient safety.
Wilson F, Gentile T, Joseph E, Tersigini AR.
Medical Services, St. John Health System, Warren, Michigan, USA.
The first Institute of Medicine (IOM) report refocused the whole health profession on patient safety. The goals described in this article were the result of the St. John Health System doing the same. We believe that a comprehensive approach rather than just focusing on adverse drug events was important. This refocusing has been for the most part uniform and identical throughout the system. This article describes how, based on the literature supporting the first IOM report, St. John Health System developed a comprehensive approach to improving patient safety and how that was implemented in our 8 hospital system with independent medical staffs.
PMID: 12593374 [PubMed - indexed for MEDLINE]

37: Qual Saf Health Care 2003 Apr;12(2):119-21

Human factors engineering design demonstrations can enlighten your RCA team.
Gosbee J, Anderson T.
National Center for Patient Safety, Department of Veterans Affairs, 24 Frank Lloyd Wright Drive, Ann Arbor, MI 48106, USA Columbia Veterans Affairs Medical Center, 800 Hospital Drive, Columbia, MO 65201, USA.
A case study is presented, based on the experience of the US Veterans Affairs health system, which shows the benefits of healthcare personnel understanding human factors engineering (HFE) and how it relates to patient safety. After HFE training, personnel are better able to use a systems-oriented approach during adverse event analysis. Without some appreciation of HFE, the focus of adverse event analyses (e.g. root cause analysis (RCA)) is often misguided towards policies or an individual's shortcomings, leading to ineffective solutions. The case study followed the investigation by an RCA team of a retained sponge following cardiac surgery. The team began with a focus on the specific failings of the surgical nurse and outdated policies. HFE design demonstrations were used to redirect the team's focus to more systems-oriented issues, which could be uncovered even when events appeared to be related to policy or training, and to point them towards examining the design of systems that contributed to the event. The team was thus able to identify design flaws and make improvements to the design of the forms and computer systems that were key to preventing such events from recurring.
PMID: 12679508 [PubMed - in process]

38: Qual Saf Health Care 2003 Apr;12(2):112-118
The culture of safety: results of an organization-wide survey in 15 California hospitals.
Singer SJ, Gaba DM, Geppert JJ, Sinaiko AD, Howard SK, Park KC.
Center for Health Policy/Center for Primary Care and Outcomes Research, Stanford University, Stanford, CA 94305-6019, USA Patient Safety Center of Inquiry, VA Palo Alto Health Care System, Palo Alta, CA 94304, USA National Bureau of Economic Research, Stanford, CA 94305, USA.
OBJECTIVE: To understand fundamental attitudes towards patient safety culture and ways in which attitudes vary by hospital, job class, and clinical status.
DESIGN: Using a closed ended survey, respondents were questioned on 16 topics important to a culture of safety in health care or other industries plus demographic information. The survey was conducted by US mail (with an option to respond by Internet) over a 6 month period from April 2001 in three mailings.
SETTING: 15 hospitals participating in the California Patient Safety Consortium.
SUBJECTS: A sample of 6312 employees generally comprising all the hospital's attending physicians, all the senior executives (defined as department head or above), and a 10% random sample of all other hospital personnel. The response rate was 47.4% overall, 62% excluding physicians. Where appropriate, responses were weighted to allow an accurate comparison between participating hospitals and job types and to correct for non-response. MAIN OUTCOME MEASURES: Frequency
of responses suggesting an absence of safety culture ("problematic responses" to survey questions) and the frequency of "neutral" responses which might also imply a lack of safety culture. Responses to each question overall were recorded according to hospital, job class, and clinician status. RESULTS: The mean overall problematic response was 18% and a further 18% of respondents gave neutral responses. Problematic responses varied widely between participating institutions. Clinicians, especially nurses, gave more problematic responses than non-clinicians, and front line workers gave more than senior managers.
CONCLUSION: Safety culture may not be as strong as is desirable of a high reliability organization. The culture differed significantly, not only between

hospitals, but also by clinical status and job class within individual institutions. The results provide the most complete available information on the attitudes and experiences of workers about safety culture in hospitals and ways in which perceptions of safety culture differ among hospitals and between types of personnel. Further research is needed to confirm these results and to determine how senior managers can successfully transmit their commitment to safety to the clinical workplace.
PMID: 12679507 [PubMed - as supplied by publisher]

39: Sleep 2003 Mar 15;26(2):218-25
Sleep, fatigue, and medical training: setting an agenda for optimal learning and patient care.
Buysse DJ, Barzansky B, Dinges D, Hogan E, Hunt CE, Owens J, Rosekind M, Rosen R, Simon F, Veasey S, Wiest F.
The difficult issues surrounding discussions of sleep, fatigue, and medical education stem from an ironic biologic truth: physicians share a common physiology with their patients, a physiology that includes an absolute need for sleep and endogenous circadian rhythms governing alertness and performance. We cannot ignore the fact that patients become ill and require medical care at all times of the day and night, but we also cannot escape the fact that providing such care requires that medical professionals, including medical trainees, be awake and functioning at times that are in conflict with their endogenous sleep and circadian physiology. Finally, we cannot avoid the reality that medical education requires long hours in a constrained number of years. Solutions to the problem of sleep and fatigue in medical education will require the active involvement of numerous parties, ranging from trainees themselves to training program directors, hospital administrators, sleep and circadian scientists, and government funding and regulatory agencies. Each of these parties can be informed by previous laboratory and field studies in a variety of operational settings. including medical environments. Education regarding the known effects of sleep. circadian rhythms, and sleep deprivation can help to elevate the general level of discourse and point to potential solutions. Empiric research addressing the effects of sleep loss on patient safety, education outcomes, and resident health is urgently needed: equally important are the development and assessment of innovative countermeasures to maximize performance and learning. Addressing the economic realities of any changes in resident work hours is an essential component of any discussion of these issues. Finally, work-hour regulations may serve as one component of improved sleep and circadian health for medical trainees. but they should not be seen as substitutes for more original solutions that rely less on enforcement and more on collaboration. By working together to address the problems of sleep and fatigue in its own trainees, the medical field can provide a valuable legacy to patients and to future generations of healthcare providers--a legacy or optimal medical education, healthy doctors, and healthy patients.
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